

ISSUE BRIEF

Surveillance Within the Division of Youth Services: How current efforts to monitor the use of physical restraints fall short.

In August 2023, staff at a Colorado Department of Human Services – Division of Youth Services (DYS) youth center moved to physically restrain a 13-year-old in their care. As staff attempted to force him down to the floor, his face slammed into a metal doorframe. The impact resulted in a gash on the youth’s face that required a series of stitches to close. A written report prepared by the staff that restrained the youth stated the physical contact was necessary because the youth made verbal threats moments before.

Less than a year prior, a different youth at a DYS youth center was in a verbal disagreement with staff when he tossed items off a staff member’s desk. Staff in the room moved to restrain the youth. One member utilized an unauthorized technique during the restraint. Again, the staff involved in the incident filed a report stating that the youth’s verbal comments, and his failure to respond to verbal commands made by staff, warranted physical restraint.

Twelve months before that, during October 2022, a different youth was being closely monitored after experiencing a concussion at a DYS youth center. Medical professionals at the center had advised staff to avoid physical contact with the youth. However, staff ultimately used physical force to restrain the youth after, staff reported, the youth made verbal comments that warranted such a response. The youth, however, would later report that he had been antagonized by the staff with racist language.

In each of these cases, multiple entities viewed video of the physical force used to restrain the youth. The images on those videos helped them see how staff used different physical management techniques, how the youth was escorted out of a room or whether documentation accurately reflected the incident. But any determination that the use of force was justified was made without complete information. That is because the videos of each incident only captured images of physical contact. They did not include any audio recordings of the verbal exchange staff later claimed were cause enough to use physical force.

The use of physical force within DYS youth centers has been at the center of discussions in Colorado for more than a decade. In fact, during the past two fiscal years, the Office of the Colorado Child Protection Ombudsman (CPO) was contacted by 130 youth currently or formally residing in DYS facilities. In total, 25 percent of those cases concerned staff misconduct or the misuse of physical restraints – the majority of which were called in by youth themselves. DYS leadership, legislators, attorneys and families have long worked to decrease the use of violence in youth centers each year.¹ While various components of the issue have been addressed – including the use of mechanical devices and de-escalation techniques – physical restraints are still used today. During these physical restraints, youth have sustained broken bones, abrasions, concussions and broken teeth.

These case examples are a small sampling of the physical force used to restrain youth in DYS centers each year. While they are a small sampling, they represent a pervasive issue regarding the barriers in monitoring the safety and care of youth in such facilities. These concerns are compounded by data released by DYS that shows youth of color are more likely to be subject to the use of restraint or physical force.²

The CPO routinely receives cases that include the use of physical restraint on youth in DYS youth centers. In many of these cases, DYS staff claim that the reasons for physically managing a youth are because a youth made inappropriate verbal statements or threats, or alternatively, the youth refused to adhere to verbal commands made by staff. Like other entities in Colorado charged with reviewing such cases, the CPO has access to reports created by staff, surveillance videos from inside facilities and applicable protocols and laws. However, without audio recordings of these incidents, the CPO and other entities reviewing these cases have no effective way to determine if the use of physical force in these cases is justified. Without this ability, no one can provide meaningful monitoring or recommendations for improvement. Given these long-standing and escalating concerns, the CPO is recommending an overhaul of the existing surveillance systems to provide audio surveillance in addition to video surveillance as a means of improving facility security and the well-being of youth.

CURRENT SYSTEMS AND REVIEWS IN COLORADO

The CPO works to improve the state's child protection system. Within the agency's broad purview falls the DYS.³ The CPO works with staff working in youth centers, youth residing in youth centers and those concerned about youth safety and well-being. The DYS posts materials about the CPO throughout youth centers, and youth have direct phone access to the agency. The CPO is also a named resource in both the youth and family handbooks.

During the past several years, the CPO has observed violent physical interactions between staff and youth in DYS centers. Through the agency's review of video surveillance, youth have been pushed into walls, shoved and thrown to the floor, sometimes, by multiple adults. Unfortunately, over time, the CPO has not seen a decrease in these types of cases.

The CPO works diligently to investigate the concerns brought to the agency. These cases involve a deep review of incident reports, grievance forms, medical documentation and video surveillance – as well as communication with the youth and youth center staff. Despite these efforts, the CPO continues to identify that the existing surveillance system within the DYS' youth centers is a barrier to adequately and thoroughly investigating complaints. This also impacts the quality of recommendations the CPO may make regarding policy or practice improvements regarding youth and facility safety.

Division of Youth Services

In Colorado, the Colorado Department of Human Services-Division of Youth Services (DYS) currently operates fifteen secure youth centers.⁴ The DYS is responsible for the supervision, care and treatment of youth held in secure (locked and gated) settings pre- and post-adjudication, these are the juvenile or youth equivalents of adult jails and prisons.⁵ The DYS also provides parole services to youth after commitment to a DYS youth center.⁶ Youth who live in these facilities are not allowed to leave. While in these facilities, youth are assigned to a room, wear

¹ The CPO defines "staff misconduct" in these cases as distinct from physical restraints. Examples of possible staff misconduct include, intentional denial of services to youth, inequitable treatment, discrimination and inappropriate relationships between staff and youth.

² See DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024

³ The Division of Youth Services is formally known as the Division of Youth Corrections

⁴ Aspire Youth Services Center, Betty K. Marler Youth Services Center, Clear Creek Youth Services Center, Gilliam Youth Services Center, Golden Peak Youth Services Center, Grand Mesa Youth Services Center, Marvin W. Foote Youth Services Center, Platte Valley Youth Services Center, Prairie Vista Youth Services Center, Pueblo Youth Services Center, Rocky Mountain Youth Services Center, Spring Creek Youth Services Center, Summit Youth Services Center, Willow Point Youth Services Center, Zebulon Pike Youth Services Center

⁵ DYS Key Terms identify a secure youth center as having locked doors, time-released locked panic bar door hardware, and/or secure perimeter boundaries to prevent youth from escaping.

⁶ State of Colorado, Joint Budget Committee, DHS-OCYF Staff Figure Setting FY 2023-24

assigned clothing and are required to adhere to a strict schedule. Youth are separated from their families and communities and are dependent on the DYS for connection to the outside world.

Surveillance cameras are a standard feature in all juvenile facilities. The systems are designed to: (1) Detect and prevent specific behaviors such as contraband smuggling, self-harm and escape; (2) Facilitate the coordination of incident responses; and (3) Provide a training and accountability function for staff to ensure appropriate treatment of youth in the facility. Surveillance systems serve to protect both youth and staff from misconduct. It is common for youth in these facilities to be physically restrained when staff have made the determination that an emergency exists.⁷ When a restraint happens, youth may be injured in the process. When this occurs, there are systems in place to assess whether protocols were followed and if the facts necessitating the restraint was accurately determined to be an emergency. To assess this, they often use video surveillance systems in addition to witness statements, medical records and incident reports to determine what occurred. Youth may face additional criminal charges as can staff for their misconduct.

DYS Physical Restraint Policy

DYS policy allows staff to use physical force and protective devices. The established policy notes that to ensure the safety of all youth in the care and custody of the DYS, and to prevent injury to youth and employees, that physical responses and protective devices may only be used in an emergency and after the failure of less restrictive alternatives.⁸ Staff determine when an emergency exists and whether the youth is determined to be a serious, probable or imminent threat of bodily harm to themselves or others, and whether there is a present ability to affect such bodily harm.⁹

HISTORY OF THE ISSUE

Restraints at the Center of Reform Efforts

The use of physical restraints within DYS youth centers – and efforts to reduce the number of these incidents – has been the focus of many legislators, agencies and advocates for more than a decade. The impacts such restraints have on a youth’s physical and mental health are well documented. These concerns received heightened attention in 2017, after the American Civil Liberties Union (ACLU) published its report, *Bound and Broken*. The investigative report highlighted how Colorado’s DYS youth centers were contributing to a culture of violence for youth in their charge.¹⁰ The report found that violence within the state’s facilities had increased, that youth and staff reported feeling unsafe and that staff were routinely using force and pain tactics to control youth. The report recommended transforming the state’s system to ensure that a culture of caring and true rehabilitation was available to one of our state’s most vulnerable populations. It was also emphasized that transforming this culture would require a paradigm shift.

The release of the report spurred several legislative efforts to reform the DYS system. One such effort was the passage of House Bill 17-1329. The bill stated: “Fundamental cultural change is needed at the division [DYS] in order to provide for the safety of youths and staff and to effectuate real and lasting personal change for youths in the division’s care.”¹¹ The legislation instituted a number of requirements, including:

- Requiring the DYS to annually report recidivism rates and educational outcomes;
- Requiring the Office of the State Auditor review the reports to ensure accuracy and quality of reporting; and

⁷ DYS Policy S-9-4, Security and Control

⁸ DYS Policies, Chapter 9, Policy 9.4; Physical response is defined as “the physical action of placing hands on an individual in order to restrain movement. Any approved method or device used to involuntarily limit freedom of movement, including but not limited to bodily/physical force, or protective devices.”

⁹ C.R.S. 26-20-102; CDHS DYS Key Terms

¹⁰ *Bound and Broken: How DYC’s culture of violence is hurting Colorado Kids and what to do about it.* Colorado Safety Coalition, ACLU, February 2017

¹¹ Colorado House Bill 17-1329

- Requiring the DYS to use a third-party agency to assess the DYS's de-escalation, physical management and safety policies and practices; as well as its provision of trauma-informed care.¹²

Although HB 17-1329 and additional legislation was passed to curb the use of restraints and further monitor the use of seclusion,¹³ the CPO continues to have concerns regarding the experiences of those under the care of the DYS. Not unlike what was uncovered by the Bound and Broken report, the CPO continues to hear directly from youth about the injuries they have sustained because of being unnecessarily or excessively physically restrained, how it felt to be isolated from their peers or denied basic rights and services.

To truly understand if these efforts and others like them have improved the conditions and care provided to youth, additional consideration must be made to ensure entities like the CPO have all the information necessary. Presently, the widest gap in that information is the ability to review audio recordings of incidents to verify the accuracy of incident reports and personal narratives. Without this information, third-party reviewers have no way to independently assess whether the physical management was justified.

Similarities in Adult Corrections

While the CPO acknowledges that the DYS is not a traditional correctional system structure with law enforcement officers, in many ways they are more similar than not. For example, youth are housed in secure facilities and are dependent on DYS staff to meet their needs, including access to bathrooms, phones, visitors and medical care. Most importantly, DYS staff are permitted to use physical force and seclude youth. As discussed, many youth experience these incidents as excessive, unnecessary and traumatic. The CPO also believes that the adult correctional system and law enforcement communities have embraced the increase of surveillance devices and can provide the juvenile justice system with guidance and insight as to how they have undergone this transition. Throughout the last decade, the Colorado General Assembly has prioritized legislation that recognizes that enhanced surveillance is critical to creating transparency, accountability and trust in these systems.

In 2015, House Bill 15-1285 created a body-worn camera grant program for use with law enforcement agencies in Colorado, and a body-worn camera study committee. The body-worn camera study group examined best practices and published a report with their recommendation, citing that camera use is expanding for many reasons – evaluating and strengthening performance, enhancing transparency and accountability, and investigating and resolving complaints. Although the committee reviewed the use of body-worn cameras through the context of law enforcement use, the group study explained that officer safety and the safety of the public is of utmost importance when developing policies related to the cameras.¹⁴ Additionally, the bill declared that the emergence of body-worn cameras within law enforcement settings had positive impacts on policing throughout the state and conveys the message that the actions of law enforcement are a matter of public record and concern.¹⁵

¹² Colorado House Bill 17-1329

¹³ Colorado House Bill 16-1328

¹⁴ Recommendations Regarding Body-Worn Camera Policies in Colorado, Pursuant to House Bill 15-1285, February 2016

¹⁵ Colorado House Bill 15-1285

In 2020, Senate Bill 20-217 required all local law enforcement agencies and the Colorado State Patrol to issue body-worn cameras to their officers in specific settings. Officers must wear the body-worn cameras when they are performing a task that requires an anticipated use of force.¹⁶ Again, the goal with this legislation was to enhance the integrity of law enforcement. And according to the Division of Criminal Justice, there has been approximately \$5 million dollars spent on providing body-worn cameras to law enforcement agencies across the state.¹⁷

Through collaboration and innovation, the law enforcement community was able to identify a solution to transparency and trust issues. They then successfully scaled it to well over 200 agencies, across 64 counties. The CPO believes that this model provides a framework for a similar process to be done in the state's fifteen youth-serving facilities. The priority for youth safety would dictate that we do so.

ANALYSIS

During Fiscal Year 2023-24, the CPO was contacted by 70 youth who expressed concern for the treatment and care they received while living in youth centers. The CPO's cases include concerns regarding the use of a physical responses and protective devices.¹⁸ Although the DYS is permitted to use physical force on a youth when determined appropriate, CPO clients often express concern regarding the amount of force used, particularly when youth are seriously injured.

The CPO's review of these cases demonstrated that, seven years after the Bound and Broken report was published, youth are still reporting instances of excessive force, poor treatment from staff and the misconduct of staff. Forty-seven clients reported concerns specific to excessive force and staff misconduct, this represents a 27 percent increase in the number of cases reported to the CPO the previous year.¹⁹ Additionally, these issues are further exacerbated by the inadequacy of the existing surveillance systems to represent transparent and accurate depictions of interactions between youth and DYS staff.

Currently, DYS youth centers use a surveillance system that does not have audio capacity, meaning there is no record of what is being said by either party. The lack of audio availability is a barrier when attempting to review concerns of institutional abuse, child maltreatment and excessive force related to physical restraints. As such, the CPO has to piece together whether an incident between staff and a youth escalated and required a restraint. It is important to understand the incident in its entirety when reviewing these cases. Unfortunately, the CPO is currently unable to achieve this level of review because the DYS surveillance system only captures video of each incident. At best, this system provides half the information needed to assess these cases.

The remainder of the information comes from those who may have the most to lose by being forthright. Specifically, the incident reports created for each physical restraint are made by the staff members involved. These reports are often the only official document detailing what led to the use of physical restraints – effectively allowing the staff who utilized physical force the position to provide the only information that can establish whether the force was justified. In several cases reviewed by the CPO, the agency determined that staff who implemented a physical restraint to control a youth, did so after inaccurately determining an emergency existed. As a result, the youth was subjected to unnecessary restraint, trauma and, in some cases, injuries.

¹⁶ See C.R.S. 24-31-902 (II)(D)

¹⁷ See Colorado Department of Public Safety, Division of Criminal Justice, Body Worn Camera Funding: <https://dcj.colorado.gov/body-worn-camera-funding>

¹⁸ See CDHS DYS Key Terms defines "Protective Devices" are devices used to involuntarily restrict the movement of a youth or the movement or normal functions of a portion of a youth's body; handcuffs, shackles, and transport belts are considered approved protective devices

¹⁹ The CPO received 37 personnel/restraint related cases in FY 2022-23 and 47 similar cases in FY 2023-24.

Increased Need for Transparency and Care

During the past five years, the CPO has observed that youth living in youth centers have increasingly complex needs. It is common for youth in these settings to have mental and behavioral health needs, experience as victims of child abuse and neglect and/or be diagnosed with disabilities. The DYS reported that during the past two fiscal years the agency experienced the highest percentage of youth requiring mental health and substance use treatment, compared to the previous 16 years.²⁰ These youth need services and an environment capable of providing care and rehabilitation so that they may successfully return to their families and communities.

The CPO is charged with advising the public, legislators and stakeholders regarding systemic issues impacting the DYS. This includes families of youth who are residing, or resided, in a youth center. Without the CPO's ability to fully investigate complaints within the DYS, youth and families do not have true access to an independent review of their concerns. Through the investigation of these complaints, the CPO independently reviews case documentation, video surveillance footage, staff-generated incident reports and DYS Policy. The CPO has consistently observed discrepancies in staff and youth reports of these incidents, often involving incidents of physical responses. Because the current system lacks adequate surveillance, the CPO is unable to conclude whether verbal statements made by either party contributed to an incident or were in fact egregious enough to constitute an "emergency." Without audio, there is no definitive account of the events and/or resolution to the complaint.

Other agencies are also impacted by the lack of audio availability. Often, law enforcement and county human services departments are tasked with investigating assaults and allegations of child abuse and neglect within the DYS youth centers. In these instances, professionals must rely on witness statements from youth or staff, incident reports and video surveillance. It is common for these incidents to have been initiated because of a verbal altercation, threat or combination of non-verbal and verbal actions. Currently, there is no way for any agency reviewing these cases to independently confirm what the youth or staff communicated prior to a restraint.

Youth Support Additional Surveillance

Youth have expressed to the CPO that they would support improving the surveillance systems within the DYS youth centers as they believe that staff are aware of blind spots within camera systems and that staff use the lack of audio to make threats, disparage or intimidate them, which cannot be proven after the fact. Youth have expressed that better systems would provide them with a more equitable grievance process and that there may be a decrease in incidents of excessive force if there was a better accountability mechanism.

Legal professionals have expressed the importance of ensuring youth are properly advised of how the technology will be utilized. While some legal professionals have expressed concerns regarding youth confidentiality, the majority are supportive of expanded surveillance systems as a means to enhance youth safety. This is largely a result of their observations of an increase in excessive force incidents and the difficulty they have accessing incident reports and surveillance videos. These professionals have explained that it can take weeks or longer to work through these requests and the majority of the requests are denied, unless a subpoena has been granted requiring the information to be released. Of particular concern to these professionals is that in many of these scenarios, youth are often portrayed as the instigator and other professionals (magistrates, judges, district attorneys, parole board, therapists) may presume that the incident demonstrates the youth is unwilling to follow rules or comply with programming. These conclusions can dramatically impact a youth's future. There is little to no recourse for youth to challenge these presumptions. The CPO has yet to observe a case in which the DYS provides the court with information demonstrating the context or additional details for when a DYS staff has been found to have used excessive force or initiated a physical management without justification. This is often left to those professionals in defense roles, who are unable to obtain the records in time.

²⁰ CDHS DYS FY 2022-2023 Annual Report

Internal Review by DYS Shows Need for Audio Surveillance

Biannually, the DYS compiles and reports on data related to the statewide use of restraints and seclusion to the Youth Restraint and Seclusion Working Group (Working Group).²¹ In the most recent report (which detailed incidents between March 2023 and August 2023), 465 unique youth experienced a restraint technique approximately 4,614 times.²² To clarify, one youth may experience multiple restraints (techniques) within the review period.

Compared to the previous six-month review period (September 2022 to February 2023), there was a 10 percent increase in youth who were restrained, and a 34 percent increase in the number of restraint techniques used. Additionally, instances in which staff used physical force increased 37 percent. The use of mechanical restraints – such as handcuffs, shackles and belts – increased by 29 percent.²³ All of these methods are approved and designed to involuntarily restrict the youth's movement.

The DYS does not report on whether internal reviews of restraints found the use of force justified or whether injuries were sustained because of a restraint.

Black youth represent 38 percent of these restraints but make up 23 percent of the youth centers' population.²⁴ This is particularly troubling as it continues to demonstrate that youth of color and male youth are restrained more often.²⁵ The CPO's data also reflects this issue as the agency receives a disproportionate number of calls from youth of color.²⁶ Youth of color have reported to the CPO that they often deal with staff using racial slurs and language to provoke them. These youth believe that staff do this because there is no way to corroborate their use of offensive language on the surveillance footage.

In 2023, it was determined that the Working Group should continue to review the use of restraints and seclusion, as there are no other requirements for DYS to capture or report data related to the use of restraint and seclusion to the public. Additionally, without the requirement to provide such data, there would be no public forum for stakeholders to meet with DYS to discuss their concerns, learn more about the data being reported and request changes to the way data is reported and collected.²⁷

The Division of Youth Services Quality Assurance (DYSQA/QAYS) also conducts compliance reviews and quarterly monitoring of the state's youth centers. This unit provides oversight to the DYS to make sure the facility runs safely. The DYSQA/QAYS conducts annual audits and monitoring visits to promote positive change in facilities and provide expertise regarding safety and security, clinical and medical services and training. Their purpose is to empower people and agencies with information and services to deliver high-quality programming to youth residing in youth centers.²⁸ However, there is little to no publicly available data about the work this unit conducts. Through a review of public information, the CPO was unable to locate any monitoring or annual audit reports, or redacted reports so that the public and those being served by the DYS could be informed of both the strengths and areas of improvement.²⁹

The CPO is aware that the DYSQA/QAYS often reviews incidents involving the use of force and makes recommendations to improve practice. These recommendations, however, are not available to the public.

²¹ See Colorado House Bill 15-1285, Youth Restraint and Seclusion Working Group; C.R.S. 26-20-110

²² DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, inclusive of all restraint techniques

²³ DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, inclusive of all restraint techniques; a side hold temporarily immobilizes the youth's hand and feet

²⁴ DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, Aggregate Summary – Restraint Techniques

²⁵ DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, Aggregate Summary – Restraint Techniques

²⁶ In the FY 22-23, 25 out of 58 CPO youth client identified themselves as a race other than Caucasian.

²⁷ Colorado Department of Regulatory Agencies, 2023 Sunset Review Report, Published October 13, 2023.

²⁸ See Colorado Department of Human Services, Division of Youth Services Quality Assurance: <https://cdhs.colorado.gov/dysqa>

²⁹ DYSQA and DYS Office of Quality Assurance

Prioritizing Improvement

The CPO has met with the DYS consistently over the last two years to discuss CPO cases, DYS data and concerns related to the adequacy of the surveillance system. The DYS acknowledges the CPO's concerns for the agency and other agencies with similar concerns. Repeatedly, the DYS has stated two main reasons that enhancing the surveillance system has not taken place.

- First, that systems requiring staff to wear body-worn cameras do not align with the DYS' trauma-informed approach they are working to maintain. This is largely because DYS believes that this type of approach has the tendency to pit youth and staff against each other.
- Second, equipping the state's youth centers and staff with a new surveillance system that allows for the review of audio recordings is financially prohibitive.

The CPO has continued to suggest alternative options such as equipping new facilities with current whole surveillance technology that encompasses both audio and video, so that facilities are not left to piecemeal their systems together with left over money from their budgets. Despite this recommendation, and millions of dollars spent during the past several years on new facilities and ongoing facility upgrades, audio surveillance has not been prioritized.

The decision not to prioritize updated surveillance systems in Colorado, sits in contrast to agencies in other states facing similar constraints. During the past decade, agencies in other states have not only prioritized the change but have found the ability to review audio recordings has contributed to a decrease in violence. Some examples include.

- Ohio: the Indian River Juvenile Correctional Facility implemented body-worn cameras in its facility after a 2022 incident in which 12 youth barricaded themselves in the facility due to ongoing complaints and concerns about the conditions and safety within the facility.³⁰ A year after implementation, the facility reported a 31% decrease in violence against staff and an almost 40% decrease across the three-facility campus.³¹ The facility partially attributed a decrease in violence due to the introduction of body-worn cameras.
- Louisiana: Youth services implemented body-worn cameras in juvenile correctional facilities in 2022. The policies outlining their use explained that the purpose for the increased surveillance is to provide for enhanced transparency and accountability in interactions between staff and youth, noting that staff's entire shift will be recorded, and that the camera will record and store both audio and video.³²
- Wisconsin: In 2015, a Wisconsin juvenile detention center implemented body-worn cameras after several reports of abuse by staff.³³ The facility and Division of Juvenile Corrections also completed a review of technology to ensure that there was broader monitoring and recording of surveillance footage, and installed additional video cameras in critical areas and implemented a "comprehensive camera upgrade project." Staff explained that these steps allowed them to make youth safety a top priority.

Conversely, during the past two fiscal years in Colorado, the DYS has built new youth centers, remodeled older centers and made small technical upgrades to facilities throughout the state. In each instance, the DYS elected to install or repair systems that lack the capacity to capture audio.

³⁰ See "[Ohio juvenile facility deploying bodycams after barricade](#)" Megan Sims, Cleveland.com: October 24, 2022, Distributed by Corrections1 Newsletter

³¹ Response to safety incidents include deploying body-worn cameras on staff, retraining staff on verbal de-escalation techniques, among others. <https://www.news5cleveland.com/news/local-news/we-follow-through/staff-attacks-havent-stopped-at-indian-river-juvenile-correctional-facility-per-union-president>

³² State of Louisiana, Office of Juvenile Justice, C.2.C.2.30, Field Operations, Security, Body Cameras

³³ See "[Reports of Juvenile Inmate Abuse Prompts Prison to Adopt Body Cams](#)" Matthew DeFour, The Wisconsin State Journal, December 15, 2015, Distributed by Government Technology

CONCLUSION AND RECOMMENDATION

Youth living within Colorado's DYS youth centers deserve to be kept safe. When they have concerns about their safety or how they are being treated, they have a right to have those complaints heard by an independent agency. These complaints highlight the daily experiences of vulnerable youth and can often help identify trends or areas for system improvement.

Despite the recommendation in Bound and Broken for increased youth safety and public transparency, the system has not gone far enough to improve the experience and living conditions for youth in Colorado's secure youth centers. Through the CPO's work and the work of other agencies, the inadequacy of the surveillance system has highlighted that the system does not have the resources to adequately review incidents of concern, make timely and appropriate recommendations to improve the safety and experience for youth, or a transparent mechanism to understand safety in each facility.

Even when building new youth centers, remodeling older ones and making smaller technical upgrades, the DYS has consistently chosen to install or repair systems that lack the capacity or potential for audio.

The CPO makes the following recommendations:

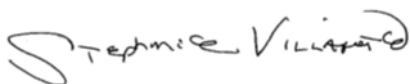
1. The DYS overhaul the existing surveillance system to include comprehensive audio and video coverage throughout the facilities.
2. The DYSQA/QAYS identify a public reporting mechanism to share information learned regarding their monitoring visits, annual audits and individual incident reviews on a consistent and recurring basis.
3. The DYS provide the Youth and Seclusion Working Group with additional data, including the following:
 - a. The number of restraints determined to be justified and the number of restraints determined to be unjustified. For each determination, the data should include information explaining the basis and rationale for the determination.
 - b. The number of times a youth sustains serious bodily injury during a restraint.
 - c. Youth race and ethnicity information related to recommendations 3(a) and 3(b).

Without the availability of audio surveillance in combination with video surveillance, these complaints cannot be fully reviewed by agencies such as the DYS, law enforcement, county human services departments and the CPO. The CPO is hopeful that the child protection system will take a meaningful and key step toward improving transparency within DYS youth centers and prioritizing the safety and experiences of youth in its care.

Pursuant to C.R.S. 19-3.3-103(2), the CPO respectfully submits this report to the citizens of Colorado, child protection stakeholders and the Colorado General Assembly.



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